

FILED JUL 9 1946 STANDARD CERTIFICATE OF DEATH

State File No. 97

Registration District No. 2

Primary Registration District No. 3017

Registrar's No. 2099

1. PLACE OF DEATH:

(a) County: Cooper

(b) City or town: Booneville

(c) Name of hospital or institution: Ravensway Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 2 wks.
(Specify whether years, months or days)

In this community _____
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State: Mo (b) County: Cooper

(c) City or town: Booneville
(If outside city or town limits, write "RURAL")

(d) Street No. _____
(If rural, give location)

(e) If foreign born, how long in U. S. A. _____ years.

3. (a) PRINT FULL NAME: Emmie Horn Hardin

3. (b) If veteran, name war: ✓

3. (c) Social Security No. _____

4. Sex: Female

5. Color or race: White

6. (a) Single, widowed, married, divorced: Married

6. (b) Name of husband or wife: Mack Hardin

6. (c) Age of husband or wife if alive: 47 years

7. Birth date of deceased: Oct. 29 1898
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>47</u>	<u>7</u>	<u>18</u>	hr. min.

9. Birthplace: Benton Co. Mo.
(City, town, or county) (State or foreign country)

10. Usual occupation: Housewife

11. Industry or business: _____

MOTHER FATHER

12. Name: Emmie Oscar Horn

13. Birthplace: Benton Co. Mo.
(City, town, or county) (State or foreign country)

14. Maiden name: Mary A. Bailey

15. Birthplace: Benton Co. Mo.
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature: Mildred Wilder

(b) Address: 900 E. 11th St. K.C. Mo.

17. (a) burial (b) Date thereof: _____
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation: Slater Mo.

18. (a) Signature of funeral director: Slater Hill Brother

(b) Address: Slater Mo.

19. (a) _____ (b) Clay Mann
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 17
year 1946 hour 6 minute 05 P. M.

21. I hereby certify that I attended the deceased from June 7
_____ 1946, to June 17 1946
that I last saw her alive on June 17 1946
and that death occurred on the date and hour stated above.

Immediate cause of death: Stemorrhage in medulla oblongata

Due to: Thrombosis

Due to: _____

Other conditions: g30
(Include pregnancy within 3 months of death)

PHYSICIAN

Major findings: App. declivity
Of operations: Chronic cystic app. declivity

Of autopsy: non

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify): _____

(b) Date of occurrence: _____

(c) Where did injury occur? _____
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____ (Specify type of place)

(e) Means of injury: _____

23. Signature: Alena R. ... (M. D. or other)

Address: Booneville, Missouri Date signed: June 17 1946

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

WHILE TRAINING USE ONE-PIECE SYSTEM INK—MAKE A PERMANENT RECORD

RECEIVED

District Health Officer No. 8,

District File Number.....

Date Filed 7-3-46

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

....., Registered Apprentice No.....
working under my personal supervision.

Signed A. C. Hill
Licensed Embalmer No. 3090
P. O. Address State mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.

Registration District No. 82

Primary Registration District No. 3017

1. PLACE OF DEATH:
(a) County Cooper
(b) City or town Boonville
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether _____)
In this community _____ years, months or days

3. (a) PRINT FULL NAME Eunice H. Hardin
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____

7. Birth date of deceased Oct 29 (Month) (Day) (Year)

8. AGE: Years 47 Months 7 Days _____ (less than one day) _____ hr. _____ min.

9. Birthplace _____ (City, town, or county) (State or foreign country) Mo

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER

12. Name _____

13. Birthplace _____ (City, town, or county) (State or foreign country)

14. Maiden name _____

15. Birthplace _____ (City, town, or county) (State or foreign country)

16. (a) Informant _____

(b) Address _____

17. (a) _____ (b) Date thereof _____ (Month) (Day) (Year)
(Burial, cremation, or removal)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) Clay Morris (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State _____ (b) County _____
(c) City or town _____ (If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month July 1946 year _____ hour _____ minute _____ M.
21. I hereby certify that I attended the deceased from _____ to _____, 19____; that I last saw him/her alive on _____, 19____; and that death occurred on the date and hour stated above.
Immediate cause of death _____

Due to _____
Due to _____
Other conditions _____ (Include pregnancy within 3 months of death)

Major findings: Of operations _____
Of autopsy _____

Duration _____
PHYSICIAN _____
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence _____
(c) Where did injury occur? _____ (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____
While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature _____ (M. D. or other)
Address _____ Date signed _____

SUPPLEMENTARY

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

19852